DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 11/29/14

PRINTED: 10/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445302	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ELIZABETHTON	1641 HIGHWAY 19E ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire barrier's one (1) hour fire rated construction is maintained. (NFPA 101, 8.2.3.2.4.2 and 8.3.6.1.) The findings include: Observation and interview with the Maintenance Director, on October 14, 2014 between 7:45 a.m.and 10:00 am. confirmed unsealed penetrations in the following locations: 1) Fire rated ceiling behind the kitchen hood, 2) Attic fire rated smoke wall by the Admin access, 3) Attic fire rated smoke wall by the wall by room 310, 4) Phone room rated ceiling These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on October 14, 2014.	K 025	1. <u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</u> All unsealed penetrations, kitchen hood, Room 310 attic, attic by administration, and phone room, sealed by maintenance supervisor on October 15, 2014. 2. <u>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</u> a. All residents residing in the facility have the potential to be affected by the alleged deficient practice. The director of maintenance and the maintenance assistant audited all of the other penetrations to ensure no other deficient practice. b. No other deficient practices were found. 3. <u>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:</u> a. The director of maintenance will educate 100% of the maintenance assistants by November 1, 2014 regarding life safety regulation related to fire stop procedure. b. The director of maintenance will make facility rounds to audit for compliance for 3 months and report results of audits to the executive director.	11/28/2014
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445302	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ELIZABETHTON	1641 HIGHWAY 19E ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062 SS=D	Continued From page 1 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined sprinkler heads were free of corrosion. (NFPA 25, 5.2.1.1.1 and 5.2.1.1.2) The findings include: Observation and interview with the Maintenance Director on September 15, 2014 at 2:50 p.m. confirmed the following: 1) 2 of 4 sprinklers in the laundry were corroded. 2) 1 of 2 sprinklers by the dishwasher were corroded. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on October 14, 2014.	K 062	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The director of maintenance ordered sprinkler heads and will replace in laundry wash room (2) and dish washer room (1). 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: a. All residents residing in the facility have the potential to be affected by the alleged deficient practice. The director of maintenance and the maintenance assistant audited all the sprinkler heads to ensure no other deficient practice. b. No other deficient practices were found. 3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: a. The director of maintenance will educate 100% of the maintenance assistants by November 1, 2014 regarding life safety regulation related to sprinkler head inspections. b. The director of maintenance will make facility rounds to audit for compliance for 3 months and report results to the executive director.	11/28/2014
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a sufficient number of receptacles so as to avoid the need for extension cords or multiple outlet adapters.	K 147		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445302	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ELIZABETHTON	1641 HIGHWAY 19E ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 2 (CMS S&C: 14-46 & NFPA 99, 3-3.2.1.2 (d) (2). The findings include: Observation and interview with the Maintenance Director, on October 14, 2014 at 9:53 a.m. confirmed the resident room 310 was observed with one (1) power strip with an Oxygen concentrator plugged into it. The maintenance Director stated their policy was to not plug medical devices into power strips. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on October 14, 2014.	K 147	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Concentrator was unplugged from power strip and plugged into wall receptacle in Room 310. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: a. All residents residing in the facility have the potential to be affected by the alleged deficient practice. The director of maintenance and the maintenance assistant audited all rooms to ensure no other deficient practice on October 14, 2014. b. No other deficient practices were found. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: a. The director of maintenance will educate 100% of associates by November 1, 2014 regarding life safety regulation related to power strips and extension cords. b. The director of maintenance will make facility rounds to audit for compliance for 3 months and report results of audits to executive director. Addendum K025 3-b Audit for compliance 3 times a week for 30 days. K062 3-b Audit for compliance 3 times a week for 30 days. K147 3-b Audit for compliance 3 times a week for 30 days.	11/28/2014